COMMONWEALTH of VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

June 28, 2005

ADDENDUM No. 1 TO VENDORS:

Reference Request for Proposal:	**RFP 2005-04**
Dated:	**June 29, 2005**
Due:	**August 12, 2005**

NOTICE:

Attached are questions and responses related to RFP 2005-04.

Note: A signed acknowledgment of this addendum must be received by this office either prior to the due date and hour required or attached to your proposal response. Signature on this addendum does not substitute for your signature on the original proposal document. The original proposal document must be signed.

Sincerely,

William D. Sydnor

William D. Sydnor
Contract Management Director

Name of Firm: _____

Signature and Title: _____

Date: _____

RFP 2005-04 Addendum #1

No.	QUESTION	ANSWER
1	Under section 5.1.1, Submission Deadlines, an electronic version of the proposal is required, in Microsoft Word format. Is it acceptable to submit an electronic version in Adobe Acrobat format, to ensure no changes are made to the proposal?	The original must be in the MS Word format, but the redacted copy may be in a PDF format.
2	Under section 5.1.3 (a) the RFP states: "The Offeror must identify any contracts or agreements they have with any state or local government entity that is similar in scope to the services described in the RFP. This information will be reviewed by DMAS to ensure there are no potential conflicts of interest." Can you provide an example of a contract with a state or local government that would present a conflict of interest so that we can ensure all appropriate contracts are listed? Does this requirement relate to Virginia state and local governments only?	The language in 5.1.3.a is clear and states, "The Offeror must identify any contracts or agreements they have with any state or local government entity that is similar in scope to the services described in the RFP. This information will be reviewed by DMAS to ensure there are no potential conflicts of interest."
3	Under Section 5.2.10, references. The RFP states, "The Offeror must provide a comprehensive listing of contracts of similar size and scope that the Offeror has successfully completed, including contracts with other State Medicaid Agencies…In addition, the Offeror must provide the names, titles, addresses, and telephone numbers of three references from among commercial or government clients for whom it has performed similar work during the past three years." Can the requested references be the same as those provided under the first portion of the request?	Yes.
4	What is the proper time and method for discussing concerns regarding the proposed contract language?	During clarifications and negotiations. Bidders may present their concerns, and DMAS would evaluate and comment.
5	What transportation data is available for base data to be used in capitation rate development?	Data obtained directly from the transportation Vendor (as opposed to encounter data stored in the DMAS MMIS) were used in capitation rate development.
6	Section 2.4. Page 5. Will there be a co-payment provision in the transportation program?	No.

7	Section 2.4., page 5. Does the Commonwealth intend to pay different rates for different population categories for transportation?	Yes.
8	Section 2.4., page 5. Will there be mid-waiver amendments that impact the transportation waiver and necessitate the revision of the initial waiver projections?	There are none planned at this time.
9	Section 2.4., page 5. Are there any programmatic changes impacting the transportation program? What data is available to evaluate the impact of these changes?	None planned at this time.
10	Section 2.5., page 5. Will the Smiles for Children (dental) program be capitated beginning July 1, 2005, or will this be an Administrative Services Organization (ASO)-style program?	The program uses an ASO.
11	Section 2.6., page 6, states in part: "Submission of a report of past efforts to utilize the goods and services of such businesses (i.e., small businesses and minority and women-owned businesses) and plans for involvement on this contract are required." Is a report required? If so, what should the report include? If so, where in the proposal should it appear?	A report is not required.
12	Section 3.1., page 6. Please confirm the Contractor will be responsible for setting actuarially-sound capitation rates for the Medallion II program, FAMIS, FAMIS MOMS, PACE, Pre-PACE, and the capitated transportation program. Are there any others?	The Contractor is responsible for setting actuarially-sound capitation rates for the Medallion II program, FAMIS, FAMIS Moms, PACE, Pre-PACE, and Transportation. Over the course of the contract, the Contractor may be asked to set rates for other populations, if programmatic changes result in new capitated populations or capitated services are carved out of the Medallion II waiver but are under capitation in a new program.
13	Section 3.1., page 6. What populations (categories of aid) are covered under these capitation rates (TANF, ABD/SSI, etc.)? What population groups (institutionalized, AIDS, etc.) are carved out of these capitated programs?	Populations covered under capitation in Medallion II include TANF, TANF-related and ABD/SSI. Population groups that are excluded from Medallion II include those living in institutions, dual-eligibles (receiving Medicare and Medicaid and also those with non-Medicaid comprehensive health insurance coverage), the breast or cervical cancer group, non-IV-E foster care children, refugees, 80% FPL groups, and those covered under other comprehensive waivers (e.g., AIDS, MR, family planning).
14	Section 3.1., page 6. What services are excluded from the	The services excluded from the capitation rates are:

	capitation rates?	Abortions, case management services for recipients of Auxiliary Grants, case management for the elderly, chiropractic services, Christian Science Nurse and Sanatoria, non-emergency dental services, experimental and investigational procedures, hospice services, lead investigations, regular assisted living services provided to residents of assisted living facilities, school health services, skilled nursing facility care, inpatient mental health services rendered in a state psychiatric hospital, treatment foster care for children under age 21 years, residential treatment facility for children under 21 years, community mental health services, community mental retardation services, out-patient substance abuse treatment, residential treatment for pregnant women, and day treatment for pregnant women.
15	Section 3.1., page 6. Will the Contractor be responsible for developing the capitation rates with input from DMAS or will DMAS develop the capitation rates with oversight and sign-off from the Contractor?	The Contractor will be responsible for developing the capitation rates with input and guidance from DMAS and the Financial Workgroup, which includes MCO staff. It is expected that the contractor will provide DMAS with interim, draft rates and reports during the rate development process, so that DMAS may monitor the methods and assumptions being employed and provide input and guidance. Rates and reports are subject to DMAS approval, prior to finalization.
16	Section 3.1., page 6. How many DMAS staff currently assists in the development of the various capitation rates? What are their roles?	The Provider Reimbursement Division Director, Manager and two Analysts, and the Deputy Director of Finance assist in the development of the Medallion II capitation rates. Their roles are largely consultative and include providing data and assisting in answering questions about the data, providing information on pricing, policy and geographic changes that affect capitation rates, providing information on population characteristics included in the waivers, providing input and direction on interim/draft results during the rate development process and approval of the final rates. Other DMAS Division staff may be involved in developing the capitation rates for other waivers, including Policy Division Analysts, Health Care Services Division staff and Long Term Care Division staff.
17	Section 3.1., page 6. What is the timing for completion of each of the capitation rates? Please provide a schedule of related tasks for the upcoming contract period.	Under our current method, Medallion II Medicaid, FAMIS and PACE/Pre-PACE rates must be completed by June 1 to be effective July 1 of each year. In addition, updates to the

		Medallion II Medicaid CDPS scores, with subsequent rate changes, must be complete by December 1 to be effective January 1 of each year. The transportation rates will be reviewed annually and at the discretion of DMAS. But, we are open to changes in the various methods, including multi-year rate setting and other risk adjustment techniques. In addition, changes to the rates may be necessary as a result of legislative, programmatic and policy changes. Changes to the rates may necessitate changes to waiver cost effectiveness projections.
18	Section 3.1., page 6. How are the capitation rates used? Does the Commonwealth use the rates to establish parameters within which MCOs bid? Does it publish the capitation rates and contract with willing providers, or does it negotiate with each MCO individually?	The capitation rates are set, and DMAS contracts with willing providers. The Contractor may be asked to provide parameters for some elements used in rate development, based on different assumptions regarding factors for which point estimates may be variable or uncertain, for example, the degree of savings attained by MCO utilization management.
19	Section 3.1., page 6. For how many rate cells are capitation rates currently developed? How many geographic regions are used? Can DMAS provide a copy of the current rate cell schedule?	While we will provide the current rate cell breakouts for the various programs below, we wish to stress that the breakouts are open to discussion with the Contractor and may be modified for future rate development. The current rate cells include: • Medallion II Medicaid - 480 rate cells broken out by two broad eligibility groups, (ABD and TANF); eight age/gender groups (under 1 year, 1- 5 years, 6 – 14 years, Female 15 – 20, Female 21 - 44, Male 15 – 20, Male 21 – 44, and over 44), five geographic regions (Northern Virginia, Other MSA, Richmond/Charlottesville, Rural and Tidewater), and six MCOs. • Medallion II FAMIS – 10 rate cells broken out by two income groups (between 134% and 150% FPL and >150% FPL) and five age/sex groups (under 1, 1-5, 6-14, 15-18 male, 15-18 female). These rates are statewide. • Medallion II FAMIS Moms – These rates are currently under development, but we anticipate one or two rates. If two rates were used, they would be based on age

		(<21 and 21 and over), reflecting different benefit packages, based on age. • PACE, Pre-PACE - 20 rate cells broken out by five geographic regions and four populations (PACE dual eligible, PACE Medicaid only, Pre-PACE Dual Eligible and Pre-PACE Medicaid only). • Transportation – 35 rate cells broken out by five geographic regions and seven population groups (MR/DD, Nursing Home, Other ABD <21 years, Other ABD 21 and over, Title XXI FAMIS, TANF <21, and TANF 21 and over).
20	Section 3.1., page 6. Which rate cells are currently risk adjusted? Are any populations or services carved out of the risk-adjustment factor?	All Medallion II Medicaid rate cells are risk adjusted. Risk adjustment has not been used for Medallion II FAMIS or FAMIS Moms, transportation or PACE/Pre-PACE rates.
21	Section 3.1., page 6. Will the Contractor be responsible for running the risk-adjustment software and developing the risk-adjustment factors?	Yes.
22	Section 3.2., page 6. Have any studies been performed on the reported diagnosis data to determine its accuracy and completeness? If so, what were the results?	MCO claims data have been used for CDPS. The current Contractor works with the MCOs to ensure completeness of the data, but no formal studies have been performed on this data. A validation study was performed on encounter data submitted to DMAS by the MCOs, in anticipation of using encounter data for rate setting purposes at some future date. Distortions of the data that may have occurred when processed by the DMAS MMIS were not evaluated. Several areas of improvement were identified for both data accuracy and completeness. The MCOs were provided with data improvement plans.
23	Section 3.2., page 6. How is the diagnosis data currently transmitted to the Contractor? What format and media is used?	Diagnosis data are included in the claims data provided by the MCOs to the Contractor. MCOs submit data to the current Contractor in MS Access, D-BASE IV and V, and SAS files.
24	Section 3.2., page 6. Please confirm that encounter data has not been used to set rates. For what contract period does the Commonwealth expect to use encounter data in developing its rates?	DMAS Encounter data have not yet been used to set rates, MCO claims data directly provided to the Contractor by the MCOs have been used. There is no date set for using encounter data at this time.
25	Section 3.2., page 6. Please provide the dates encounter data was first collected in each geographic area.	Tidewater area – 1996. Adjacent to Tidewater – November 1997. Central Virginia – April 1999. Adjacent to Central

		Virginia – October 2000. Areas in Central, Southwestern and Northern Virginia – December 2001. Additional areas in Northern Virginia November 2002. Additional expansion areas are planned for September 2005 and May 2006.
26	Section 3.2., page 6. What steps does DMAS or its Contractor currently take to validate the encounter data?	During 2005, an outside contractor performed a validation study of encounter data (data submitted by the MCOs to DMAS that reside in the DMAS MMIS system, as opposed to MCO claims submitted by the MCOs to the validation contractor directly). MCOs were given a data improvement plan. DMAS is currently reviewing plans for follow-up and ongoing encounter data validation/improvement activities.
27	Section 3.2., page 6. Does DMAS currently collect financial reports for MCOs participating in the Medallion II and FAMIS program?	Yes. MCO financial reports combine Medicaid and FAMIS lines of business; the two populations are not reported separately.
28	Section 3.7., page 8. The RFP says the Contractor may be asked to develop capitation rates or perform other actuarial services for unspecified programs or services. Will DMAS amend the scope and payment provisions of the contract at the time these services are defined and agreed upon?	DMAS will amend the scope of service. Payment is made on an hourly rate basis using the negotiated rates that are prevailing during the contract period.
29	Section 4.9., page 9. The RFP suggests that the Contractor could meet with vendors. Does DMAS currently negotiate capitation rates with MCOs and, if so, is it expected that the Contractor negotiate these rates on behalf of DMAS?	The Contractor will not negotiate rates on behalf of DMAS. The Contractor will calculate the rates and will be expected to explain calculations to MCOs and answer their questions. To the extent that MCOs raise valid issues concerning the calculations, the Contractor is expected to consider revisions. That is the extent of “negotiation” in which the Contractor will be involved.

30	Section 5.1.5., page 11, states in part: "Each paragraph in the proposal must reference the paragraph number of the corresponding section of the RFP." Please clarify the format more clearly. Is the intent that each section (not paragraph) of the proposal correlate with the sections outlined in 5.2., beginning on page 12. Section 1—Transmittal Letter Section 2—Signed Cover Page Section 3—Executive Summary Section 4—Capacity Summary Section 5—Qualifications Summary Section 6—Capitation Rate Setting Process Section 7—Risk Adjustment Section 8—Waiver Cost Effectiveness Section 9—Staff Roster Section 10—Project Management Section 11—References Section 12—Additional Information	Each requirement of the RFP must be addressed in the order in which they are presented in the RFP.
31	Section 7., page 15, states in part: "At the discussion stage, non-binding estimates of total project costs, including non-binding estimates of price for services may be discussed." Please confirm that no price information is to be submitted as part of or separate from the technical proposal due August 12, 2005. If a price proposal is required, what are the requirements of the format of the price proposal?	There is no cost/price proposal required with the submission due August 12, 2005.
32	Section 8.1.1., page 15. Please provide current examples of the reports, spreadsheets, and supporting documentation DMAS is requesting in Section 8.1.1. of the RFP.	We would like prospective Contractors to submit examples of reports, spreadsheets and supporting documentation that they would propose to provide. These items should be sufficiently detailed that they reveal the rate setting methodology used so that providers can see, on an aggregate, but rate-cell specific level, the development of cost and utilization assumptions that are built into the rates and any adjustments that are made in arriving at the final rates.
33	Section 8.1.3., page 16. The RFP requests periodic meetings between DMAS staff, health plans, and the Contractor. How	Normally there are no more than three meetings per year requiring the Contractor's presence.

	many such meetings are expected during the course of a year? What other meetings requiring the Contractor's physical presence may be needed?	
34	Does the Department of Medical Assistance Services currently contract for these or similar services that were outlined in the RFP? If so, who is the contractor?	Yes, DMAS currently contracts for the services. The current Contractor is PricewaterhouseCoopers, LLP.
35	Is a Cost Proposal to be submitted with the Technical Proposal?	See response to # 31.
36	Is there an anticipated begin date for the contract?	It is anticipated that the begin date will be during the fourth quarter of calendar year 2005.
37	Are there currently deadlines established for updated capitation rates?	See question number 17.